telegram, or other communication constituting an informal claim.

[39 FR 1844, Jan. 15, 1974. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.128 Allowable rates and fees.

When it has been determined that a veteran has received public or private hospital care, the expenses of which may be paid under § 17.120 of this part, the payment of such expenses shall, except as otherwise provided in this section, be based on a prospective payment system similar to that used in the Medicare program for paying for similar inpatient hospital services in the community. Payment shall be made by using the HCFA PRICER for each diagnosis-related group (DRG) applicable to the episode of care.

(a) Payment shall be made of the full prospective payment amount per discharge, as determined according to the methodology in subparts D and G of 42 CFR part 412, as appropriate.

(b)(1) In the case of a veteran who was transferred to another facility before completion of care, VA shall pay the transferring hospital an amount calculated by the HCFA PRICER for each patient day of care, not to exceed the full DRG rate as provided in paragraph (a) of this section. The hospital that ultimately discharges the patient will receive the full DRG payment.

(2) In the case of a veteran who has transferred from a hospital and/or distinct part unit excluded by Medicare from the DRG-based prospective payment system and hospitals that do not participate in Medicare, the transferring hospital will receive a payment for each patient day of care not to exceed that provided in paragraph (i) of this section.

(c) VA shall pay the providing facility the full DRG-based rate without regard to any copayments or deductible required by any Federal law that is not applicable to VA.

(d) If the cost of length of a veteran's care exceeds an applicable threshold amount, as determined by the HCFA PRICER program, VA shall pay, in addition to the amount payable under paragraph (a) of this section, an outlier payment calculated by the HCFA PRICER program, in accordance with subpart F of 42 CFR part 412.

(e) In addition to the amount payable under paragraph (a) of this section, VA shall pay, for each discharge, an amount to cover the non-Federal hospital's capital-related costs, kidney, heart and liver acquisition costs incurred by hospitals with approved transplantation centers, direct costs of medical education, and the costs of qualified nonphysician anesthetists in small rural hospitals. These amounts will be determined by the Under Secretary for Health on an annual basis and published in the ''Notices'' section of the FEDERAL REGISTER.

(f) Payment shall be made only for those services authorized by VA.

(g) Payment by VA shall constitute payment in full and the provider or agent for the provider may not impose any additional charge on a veteran or his or her health care insurer for any inpatient services for which payment is made by VA.

(h) Medical services not included in inpatient operating costs which the DRG covers (42 CFR part 412) shall be paid or reimbursed only to the extent they are reasonable and not in excess of rates or fees the hospital or provider of services charges the general public for similar services in the community.

(i) Hospital or distinct part hospital units excluded from the prospective payment system by Medicare and hospitals that do not participate in Medicare will be paid at the national cost to charge ratio times the billed charges that are reasonable, usual, customary, and not in excess of the rates or fees the hospital charges the general public for similar services in the community.

(j) A hospital participating in an alternative payment system that has been granted a Federal waiver from the prospective payment system under the provisions of 42 U.S.C. section 1395f(b)(3) or 42 U.S.C. section 1395ww(c) for the purposes of Medicare payment shall not be subject to the payment methodology set forth in this section so long as such Federal waiver remains in effect. VA pays such a hospital in accordance with paragraph (i) of this section.

(k) Payments for episodes of hospital care furnished in Alaska that begin during the period starting on the effective date of this section through the

364th day thereafter will be in the amount determined by the HCFA PRICER plus 50 percent of the difference between the amount billed by the hospital and the amount determined by the PRICER. In order to cover this special dispensation period, claims for services provided on the enactment date of this regulation, and extending during this period, will be accepted for payment by VA until December 31 of the year following the year in which these regulations were enacted.

(Authority: Section 233, Pub. L. 99–576)

[55 FR 42853, Oct. 24, 1990. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996; 62 FR 17072, Apr. 9, 1997]

§17.129 Retroactive payments prohibited.

When a claim for payment or reimbursement of expenses of services not previously authorized has not been timely filed in accordance with the provisions of §17.126, the expenses of any such care or services rendered prior to the date of filing the claim shall not be paid or reimbursed. In no event will a bill or claim be paid or allowed for any care or services rendered prior to the effective date of any law, or amendment to the law, under which eligibility for the medical services at Department of Veterans Affairs expense has been established.

[39 FR 1844, Jan. 15, 1974. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

§17.130 Payment for treatment dependent upon preference prohibited.

No reimbursement or payment of services not previously authorized will be made when such treatment was procured through private sources in preference to available Government facilities.

[39 FR 1844, Jan. 15, 1974. Redesignated at 61 FR 21966, May 13, 1996]

§17.131 Payment of abandoned claims prohibited.

Any informal claim for the payment or reimbursement of medical expenses which is not followed by a formal claim, or any formal claim which is not followed by necessary supporting evidence, within 1 year from the date of the request for a formal claim or supporting evidence shall be deemed abandoned, and payment or reimbursement shall not be authorized on the basis of such abandoned claim or any future claim for the same expenses. For the purpose of this section, time limitations shall be computed from the date following the date of request for a formal claim or supporting evidence.

[33 FR 19012, Dec. 20, 1968. Redesignated at 61 FR 21966, May 13, 1996]

§17.132 Appeals.

When any claim for payment or reimbursement of expenses of medical care or services rendered in non-Department of Veterans Affairs facilities or from non-Department of Veterans Affairs resources has been disallowed, the claimant shall be notified of the reasons for the disallowance and of the right to initiate an appeal to the Board of Veterans Appeals by filing a Notice of Disagreement, and shall be furnished such other notices or statements as are required by part 19 of this chapter, governing appeals.

[33 FR 19012, Dec. 20, 1968. Redesignated at 61 FR 21966, May 13, 1996]

DELEGATIONS OF AUTHORITY

§17.140 Authority to adjudicate reimbursement claims.

The Department of Veterans Affairs medical installation having responsibility for the fee basis program in the region or territory (including the Republic of the Philippines) served by such medical installation shall adjudicate all claims for the payment or reimbursement of the expenses of services not previously authorized rendered in the region or territory.

[39 FR 1844, Jan. 15, 1974. Redesignated at 61 FR 21966, May 13, 1996]

§17.141 Authority to adjudicate foreign reimbursement claims.

The Health Administration Center in Denver, CO, shall adjudicate claims for the payment or reimbursement of the expenses of services not previously authorized rendered in any foreign country except Canada which will be referred to the VA Medical Center in